AMENDED IN ASSEMBLY APRIL 15, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 741

Introduced by Assembly Member Williams

February 25, 2015

An act to *amend Section 1502 of the Health and Safety Code, and to* amend Section 14132 of the Welfare and Institutions Code, relating to ~~Medi-Cal.~~ *mental health.*

LEGISLATIVE COUNSEL'S DIGEST

AB 741, as amended, Williams. ~~Medi-Cal: comprehensive~~ *Comprehensive* mental health crisis services.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law provides for a schedule of benefits under the Medi-Cal program, which includes early and periodic screening, diagnosis, and treatment for any individual under 21 years of age.

This bill would add to the schedule of benefits comprehensive mental health crisis services, including crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams, to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

Existing law, the California Community Care Facilities Act, provides for the licensing and regulation of community care facilities, as defined, by the State Department of Social Services. Existing law includes within

the definition of community care facility, a social rehabilitation facility, which is a residential facility that provides social rehabilitation services in a group setting to adults recovering from mental illness. A violation of the act is a misdemeanor.

This bill would expand the definition of a social rehabilitation facility to include a residential facility that provides social rehabilitation services in a group setting to children, adolescents, or adults recovering from mental illness or in a mental health crisis. By expanding the types of facilities that are regulated as a community care facility, this bill would expand the scope of an existing crime, thus creating a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: ~~no~~ *yes*.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) There is an urgent need to provide more crisis care alternatives to hospitals for ~~individuals~~ *children and youth* experiencing mental health crises.

(b) The problems are especially acute for children *and youth* who may have to wait for days for a hospital bed and who may be transported, without a parent, to the nearest facility hundreds of miles away.

(c) In 2012, the California Hospital Association reported that two-thirds of the people taken to a hospital for a psychiatric emergency did not meet the criteria for that level of care but the care they needed was not available.

(d) The type of care that is needed includes crisis ~~stabilization,~~ *stabilization and* crisis residential ~~treatment, mobile crisis support teams, and in-home crisis care~~ *treatment* for children.

(e) This level of care is part of the full continuum of care considered medically necessary for many children with serious

emotional ~~disturbances and adults with severe mental illnesses.~~ *disturbances.*

(f) In 2013, the Legislature enacted ~~Senate Bill 82 (Chapter~~ *the Investment in Mental Health Wellness Act (Senate Bill 82, Chapter* 34 of the Statutes of 2013) to provide one-time funding to counties to expand the availability of ~~these~~ mental health crisis care ~~facilities. However, very few of these facilities can accommodate children.~~ *services, including short-term crisis residential treatment services. However, there is currently no state licensing category for short-term crisis residential programs for children. As a result, counties wanting to expand local capacity to meet the needs of children and youth for crisis residential treatment services were ineligible for this competitive grant program.*

~~(g) There is currently no state licensing category for crisis residential programs for children. Federal Medicaid provisions require, however, that services be equal in amount, duration, and scope for all individuals within each eligibility category. It is essential that children receive the same range of services as adults with mental health conditions.~~

(g) Federal Medicaid provisions allow for federal matching funds for mental health services delivered to Medi-Cal beneficiaries under 21 years of age in psychiatric residential treatment facilities, including short-term crisis residential treatment programs. However, because there is currently no state licensing category for crisis residential treatment programs for children, California is unable to benefit from these otherwise available federal financial resources.

(h) In most ~~private health plans this level of care~~ *communities, inpatient crisis treatment* is completely unavailable for children and ~~adults~~ *youth* even though it may be medically necessary.

(i) Crisis *residential* care is an essential level of care for the ~~rehabilitation of individuals with serious emotional disturbances and severe mental illnesses,~~ *treatment of children and youth with serious emotional disturbances in a mental health crisis,* and it often serves as an alternative to hospitalization.

(j) It is imperative that public ~~and private~~ health care coverage include these services as a covered benefit.

SEC. 2. Section 1502 of the Health and Safety Code is amended to read:

1502. As used in this chapter:

(a) "Community care facility" means any facility, place, or building that is maintained and operated to provide nonmedical residential care, day treatment, adult day care, or foster family agency services for children, adults, or children and adults, including, but not limited to, the physically handicapped, mentally impaired, incompetent persons, and abused or neglected children, and includes the following:

(1) "Residential facility" means any family home, group care facility, or similar facility determined by the director, for 24-hour nonmedical care of persons in need of personal services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of the individual.

(2) "Adult day program" means any community-based facility or program that provides care to persons 18 years of age or older in need of personal services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of these individuals on less than a 24-hour basis.

(3) "Therapeutic day services facility" means any facility that provides nonmedical care, counseling, educational or vocational support, or social rehabilitation services on less than a 24-hour basis to persons under 18 years of age who would otherwise be placed in foster care or who are returning to families from foster care. Program standards for these facilities shall be developed by the department, pursuant to Section 1530, in consultation with therapeutic day services and foster care providers.

(4) "Foster family agency" means any organization engaged in the recruiting, certifying, and training of, and providing professional support to, foster parents, or in finding homes or other places for placement of children for temporary or permanent care who require that level of care as an alternative to a group home. Private foster family agencies shall be organized and operated on a nonprofit basis.

(5) "Foster family home" means any residential facility providing 24-hour care for six or fewer foster children that is owned, leased, or rented and is the residence of the foster parent or parents, including their family, in whose care the foster children have been placed. The placement may be by a public or private child placement agency or by a court order, or by voluntary placement by a parent, parents, or guardian. It also means a foster family home described in Section 1505.2.

(6) "Small family home" means any residential facility, in the licensee's family residence, that provides 24-hour care for six or fewer foster children who have mental disorders or developmental or physical disabilities and who require special care and supervision as a result of their disabilities. A small family home may accept children with special health care needs, pursuant to subdivision (a) of Section 17710 of the Welfare and Institutions Code. In addition to placing children with special health care needs, the department may approve placement of children without special health care needs, up to the licensed capacity.

(7) "Social rehabilitation facility" means any residential facility that provides social rehabilitation services for no longer than 18 months in a group setting to ~~adults~~ *individuals, including children, adolescents, and adults,* recovering from mental illness *or in a mental health crisis* who temporarily need assistance, guidance, or counseling. Program components shall be subject to program standards pursuant to Article 1 (commencing with Section 5670) of Chapter 2.5 of Part 2 of Division 5 of the Welfare and Institutions Code.

(8) "Community treatment facility" means any residential facility that provides mental health treatment services to children in a group setting and that has the capacity to provide secure containment. Program components shall be subject to program standards developed and enforced by the State Department of Health Care Services pursuant to Section 4094 of the Welfare and Institutions Code.

Nothing in this section shall be construed to prohibit or discourage placement of persons who have mental or physical disabilities into any category of community care facility that meets the needs of the individual placed, if the placement is consistent with the licensing regulations of the department.

(9) "Full-service adoption agency" means any licensed entity engaged in the business of providing adoption services, that does all of the following:

(A) Assumes care, custody, and control of a child through relinquishment of the child to the agency or involuntary termination of parental rights to the child.

(B) Assesses the birth parents, prospective adoptive parents, or child.

(C) Places children for adoption.

(D) Supervises adoptive placements.

Private full-service adoption agencies shall be organized and operated on a nonprofit basis. As a condition of licensure to provide intercountry adoption services, a full-service adoption agency shall be accredited and in good standing according to Part 96 of Title 22 of the Code of Federal Regulations, or supervised by an accredited primary provider, or acting as an exempted provider, in compliance with Subpart F (commencing with Section 96.29) of Part 96 of Title 22 of the Code of Federal Regulations.

(10) "Noncustodial adoption agency" means any licensed entity engaged in the business of providing adoption services, that does all of the following:

(A) Assesses the prospective adoptive parents.

(B) Cooperatively matches children freed for adoption, who are under the care, custody, and control of a licensed adoption agency, for adoption, with assessed and approved adoptive applicants.

(C) Cooperatively supervises adoptive placements with a full-service adoptive agency, but does not disrupt a placement or remove a child from a placement.

Private noncustodial adoption agencies shall be organized and operated on a nonprofit basis. As a condition of licensure to provide intercountry adoption services, a noncustodial adoption agency shall be accredited and in good standing according to Part 96 of Title 22 of the Code of Federal Regulations, or supervised by an accredited primary provider, or acting as an exempted provider, in compliance with Subpart F (commencing with Section 96.29) of Part 96 of Title 22 of the Code of Federal Regulations.

(11) "Transitional shelter care facility" means any group care facility that provides for 24-hour nonmedical care of persons in need of personal services, supervision, or assistance essential for sustaining the activities of daily living or for the protection of the individual. Program components shall be subject to program standards developed by the State Department of Social Services pursuant to Section 1502.3.

(12) "Transitional housing placement provider" means an organization licensed by the department pursuant to Section 1559.110 and Section 16522.1 of the Welfare and Institutions Code to provide transitional housing to foster children at least 16 years of age and not more than 18 years of age, and nonminor dependents, as defined in subdivision (v) of Section 11400 of the

Welfare and Institutions Code, to promote their transition to adulthood. A transitional housing placement provider shall be privately operated and organized on a nonprofit basis.

(13) "Group home" means a residential facility that provides 24-hour care and supervision to children, delivered at least in part by staff employed by the licensee in a structured environment. The care and supervision provided by a group home shall be nonmedical, except as otherwise permitted by law.

(14) "Runaway and homeless youth shelter" means a group home licensed by the department to operate a program pursuant to Section 1502.35 to provide voluntary, short-term, shelter and personal services to runaway youth or homeless youth, as defined in paragraph (2) of subdivision (a) of Section 1502.35.

(15) "Enhanced behavioral supports home" means a facility certified by the State Department of Developmental Services pursuant to Article 3.6 (commencing with Section 4684.80) of Chapter 6 of Division 4.5 of the Welfare and Institutions Code, and licensed by the State Department of Social Services as an adult residential facility or a group home that provides 24-hour nonmedical care to individuals with developmental disabilities who require enhanced behavioral supports, staffing, and supervision in a homelike setting. An enhanced behavioral supports home shall have a maximum capacity of four consumers, shall conform to Section 441.530(a)(1) of Title 42 of the Code of Federal Regulations, and shall be eligible for federal Medicaid home- and community-based services funding.

(16) "Community crisis home" means a facility certified by the State Department of Developmental Services pursuant to Article 8 (commencing with Section 4698) of Chapter 6 of Division 4.5 of the Welfare and Institutions Code, and licensed by the State Department of Social Services pursuant to Article 9.7 (commencing with Section 1567.80), as an adult residential facility, providing 24-hour nonmedical care to individuals with developmental disabilities receiving regional center service, in need of crisis intervention services, and who would otherwise be at risk of admission to the acute crisis center at Fairview Developmental Center, Sonoma Developmental Center, an acute general hospital, acute psychiatric hospital, an institution for mental disease, as described in Part 5 (commencing with Section 5900) of Division 5 of the Welfare and Institutions Code, or an out-of-state

placement. A community crisis home shall have a maximum capacity of eight consumers, as defined in subdivision (a) of Section 1567.80, shall conform to Section 441.530(a)(1) of Title 42 of the Code of Federal Regulations, and shall be eligible for federal Medicaid home- and community-based services funding.

(17) "Crisis nursery" means a facility licensed by the department to operate a program pursuant to Section 1516 to provide short-term care and supervision for children under six years of age who are voluntarily placed for temporary care by a parent or legal guardian due to a family crisis or stressful situation.

(b) "Department" or "state department" means the State Department of Social Services.

(c) "Director" means the Director of Social Services.

~~SEC. 2.~~

SEC. 3. Section 14132 of the Welfare and Institutions Code is amended to read:

14132. The following is the schedule of benefits under this chapter:

(a) Outpatient services are covered as follows:

Physician, hospital or clinic outpatient, surgical center, respiratory care, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology, acupuncture to the extent federal matching funds are provided for acupuncture, and services of persons rendering treatment by prayer or healing by spiritual means in the practice of any church or religious denomination insofar as these can be encompassed by federal participation under an approved plan, subject to utilization controls.

(b) (1) Inpatient hospital services, including, but not limited to, physician and podiatric services, physical ~~therapy~~ *therapy,* and occupational therapy, are covered subject to utilization controls.

(2) For Medi-Cal fee-for-service beneficiaries, emergency services and care that are necessary for the treatment of an emergency medical condition and medical care directly related to the emergency medical condition. This paragraph shall not be construed to change the obligation of Medi-Cal managed care plans to provide emergency services and care. For the purposes of this paragraph, "emergency services and care" and "emergency medical condition" shall have the same meanings as those terms are defined in Section 1317.1 of the Health and Safety Code.

(c) Nursing facility services, subacute care services, and services provided by any category of intermediate care facility for the developmentally disabled, including podiatry, physician, nurse practitioner services, and prescribed drugs, as described in subdivision (d), are covered subject to utilization controls. Respiratory care, physical therapy, occupational therapy, speech therapy, and audiology services for patients in nursing facilities and any category of intermediate care facility for the developmentally disabled are covered subject to utilization controls.

(d) (1) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(2) Purchase of drugs used to treat erectile dysfunction or any off-label uses of those drugs are covered only to the extent that federal financial participation is available.

(3) (A) To the extent required by federal law, the purchase of outpatient prescribed drugs, for which the prescription is executed by a prescriber in written, nonelectronic form on or after April 1, 2008, is covered only when executed on a tamper resistant prescription form. The implementation of this paragraph shall conform to the guidance issued by the federal Centers for Medicare and Medicaid Services but shall not conflict with state statutes on the characteristics of tamper resistant prescriptions for controlled substances, including Section 11162.1 of the Health and Safety Code. The department shall provide providers and beneficiaries with as much flexibility in implementing these rules as allowed by the federal government. The department shall notify and consult with appropriate stakeholders in implementing, interpreting, or making specific this paragraph.

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar instructions without taking regulatory action.

(4) (A) (i) For the purposes of this paragraph, nonlegend has the same meaning as defined in subdivision (a) of Section 14105.45.

(ii) Nonlegend acetaminophen-containing products, with the exception of children's acetaminophen-containing products, selected by the department are not covered benefits.

(iii) Nonlegend cough and cold products selected by the department are not covered benefits. This clause shall be implemented on the first day of the first calendar month following 90 days after the effective date of the act that added this clause, or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later.

(iv) Beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment Program shall be exempt from clauses (ii) and (iii).

(B) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may take the actions specified in subparagraph (A) by means of a provider bulletin or notice, policy letter, or other similar ~~instruction~~ *instruction,* without taking regulatory action.

(e) Outpatient dialysis services and home hemodialysis services, including physician services, medical supplies, ~~drugs~~ *drugs,* and equipment required for dialysis, are covered, subject to utilization controls.

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and X-ray services are covered, subject to utilization controls. Nothing in this subdivision shall be construed to require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable X-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses which are lost or destroyed due to circumstances beyond the beneficiary's control. Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial

dentures necessary for obtaining employment or for medical conditions that preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities administered by the department's California Children Services Program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated, is covered subject to utilization controls. When there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes,

custom-made orthopedic shoes are covered, subject to utilization controls.

Therapeutic shoes and inserts are covered when provided to beneficiaries with a diagnosis of diabetes, subject to utilization controls, to the extent that federal financial participation is available.

(*l*) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control. The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency regulations to define and establish criteria for assistive durable medical equipment in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(n) Family planning services are covered, subject to utilization controls. However, for Medi-Cal managed care plans, any utilization controls shall be subject to Section 1367.25 of the Health and Safety Code.

(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are covered, subject to utilization controls, when either of the following criteria are met:

(1) A patient with a permanent disability or severe impairment requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to develop function beyond the limited amount that would occur in the normal course of recovery.

(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in

Section 14064 to maintain the patient's present functional level as long as possible.

(p) (1) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(2) Commencing 30 days after the effective date of the act that added this paragraph, and notwithstanding the number of days previously approved through a treatment authorization request, adult day health care is covered for a maximum of three days per week.

(3) As provided in accordance with paragraph (4), adult day health care is covered for a maximum of five days per week.

(4) As of the date that the director makes the declaration described in subdivision (g) of Section 14525.1, paragraph (2) shall become inoperative and paragraph (3) shall become operative.

(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, and other prophylaxis treatment for children 17 years of age and under are covered.

(2) All dental hygiene services provided by a registered dental hygienist, registered dental hygienist in extended functions, and registered dental hygienist in alternative practice licensed pursuant to Sections 1753, 1917, 1918, and 1922 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist, registered dental hygienist in extended functions, or registered dental hygienist in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under *former* Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of *former* Section 1482 of the article.

(2) All providers enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) In-home medical care services are covered when medically appropriate and subject to utilization controls, for beneficiaries who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to patients placed in shared or congregate living arrangements, if a home setting is not medically appropriate or available to the beneficiary. As used in this section, "in-home medical care service" includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

As used in this subdivision, in-home medical care services include, but are not limited to:

(1) Level-of-care and cost-of-care evaluations.

(2) Expenses, directly attributable to home care activities, for materials.

(3) Physician fees for home visits.

(4) Expenses directly attributable to home care activities for shelter and modification to shelter.

(5) Expenses directly attributable to additional costs of special diets, including tube feeding.

(6) Medically related personal services.

(7) Home nursing education.

(8) Emergency maintenance repair.

(9) Home health agency personnel benefits ~~which~~ *that* permit coverage of care during periods when regular personnel are on vacation or using sick leave.

(10) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.

(11) Emergency and nonemergency medical transportation.

(12) Medical supplies.

(13) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.

(14) Utility use directly attributable to the requirements of home care activities ~~which~~ *that* are in addition to normal utility use.

(15) Special drugs and medications.

(16) Home health agency supervision of visiting staff ~~which~~ *that* is medically necessary, but not included in the home health agency rate.

(17) Therapy services.

(18) Household appliances and household utensil costs directly attributable to home care activities.

(19) Modification of medical equipment for home use.

(20) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.

(21) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

Beneficiaries receiving in-home medical care services are entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and applicable utilization control. Services provided pursuant to this subdivision, which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with a home- and community-based services waiver.

(t) Home- and community-based services approved by the United States Department of Health and Human Services are covered to the extent that federal financial participation is available for those services under the state plan or waivers granted in accordance with Section 1315 or 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and community-based services approvable under Section 1315 or 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.

The department shall seek any federal waivers necessary to implement the provisions of this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the

other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(w) Hospice service ~~which~~ *that* is Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.

(x) When a claim for treatment provided to a beneficiary includes both services ~~which~~ *that* are authorized and reimbursable under this chapter, and services ~~which~~ *that* are not reimbursable under this chapter, that portion of the claim for the treatment and services authorized and reimbursable under this chapter shall be payable.

(y) Home- and community-based services approved by the United States Department of Health and Human Services for beneficiaries with a diagnosis of AIDS or ARC, who require intermediate care or a higher level of care.

Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to individual beneficiaries in accordance with the client's needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director may under this section contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to eligible beneficiaries. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions

Code, and as an in-home medical service as outlined in subdivision (s).

(aa) (1) There is hereby established in the department, a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Program.

(2) The department shall seek a waiver in accordance with Section 1315 of Title 42 of the United States Code, or a state plan amendment adopted in accordance with Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code, which was added to Section 1396a of Title 42 of the United States Code by Section 2303(a)(2) of the federal Patient Protection and Affordable Care Act (PPACA) (Public Law 111-148), for a program to provide comprehensive clinical family planning services as described in paragraph (8). Under the waiver, the program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. Under the state plan amendment, which shall replace the waiver and shall be known as the Family PACT successor state plan amendment, the program shall be operated only in accordance with this subdivision and the statutes and regulations in paragraph (4). The state shall use the standards and processes imposed by the state on January 1, 2007, including the application of an eligibility discount factor to the extent required by the federal Centers for Medicare and Medicaid Services, for purposes of determining eligibility as permitted under Section 1396a(a)(10)(A)(ii)(XXI) of Title 42 of the United States Code. To the extent that federal financial participation is available, the program shall continue to conduct education, outreach, enrollment, service delivery, and evaluation services as specified under the waiver. The services shall be provided under the program only if the waiver and, when applicable, the successor state plan amendment are approved by the federal Centers for Medicare and Medicaid Services and only to the extent that federal financial participation is available for the services. Nothing in this section shall prohibit the department from seeking the Family PACT successor state plan amendment during the operation of the waiver.

(3) Solely for the purposes of the waiver or Family PACT successor state plan amendment and notwithstanding any other ~~provision of~~ law, the collection and use of an individual's social security number shall be necessary only to the extent required by federal law.

(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for under this subdivision. No other provision of law under the Medi-Cal program or the State-Only Family Planning Program shall apply to the program provided for under this subdivision.

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, without taking regulatory action, the provisions of the waiver after its approval by the federal ~~Health Care Financing Administration~~ *Centers for Medicare and Medicaid Services* and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the approved waiver in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(6) In the event that the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) or the Family PACT successor state plan amendment is no longer cost effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the

Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, "comprehensive clinical family planning services" means the process of establishing objectives for the number and spacing of children, and selecting the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

(B) All United States Department of Agriculture, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

(xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(D) A comprehensive health history, updated at the next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(E) A complete physical examination on initial and subsequent periodic visits.

(F) Services, drugs, devices, and supplies deemed by the federal Centers for Medicare and Medicaid Services to be appropriate for inclusion in the program.

(9) In order to maximize the availability of federal financial participation under this subdivision, the director shall have the discretion to implement the Family PACT successor state plan amendment retroactively to July 1, 2010.

(ab) (1) Purchase of prescribed enteral nutrition products is covered, subject to the Medi-Cal list of enteral nutrition products and utilization controls.

(2) Purchase of enteral nutrition products is limited to those products to be administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube.

Beneficiaries under the Early and Periodic Screening, Diagnosis, and Treatment Program shall be exempt from this paragraph.

(3) Notwithstanding paragraph (2), the department may deem an enteral nutrition product, not administered through a feeding tube, including, but not limited to, a gastric, nasogastric, or jejunostomy tube, a benefit for patients with diagnoses, including, but not limited to, malabsorption and inborn errors of metabolism, if the product has been shown to be neither investigational nor experimental when used as part of a therapeutic regimen to prevent serious disability or death.

(4) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement the amendments to this subdivision made by the act that added this paragraph by means of all-county letters, provider bulletins, or similar instructions, without taking regulatory action.

(5) The amendments made to this subdivision by the act that added this paragraph shall be implemented June 1, 2011, or on the first day of the first calendar month following 60 days after the date the department secures all necessary federal approvals to implement this section, whichever is later.

(ac) Diabetic testing supplies are covered when provided by a pharmacy, subject to utilization controls.

(ad) (1) Comprehensive mental health crisis services, including crisis intervention, crisis stabilization, crisis residential treatment, rehabilitative mental health services, and mobile crisis support teams, are covered.

(2) The department shall seek approval of any necessary state plan amendments to implement this subdivision. This subdivision shall be implemented only to the extent that federal financial participation is available and any necessary federal approvals have been obtained.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within

the meaning of Section 6 of Article XIII B of the California Constitution.

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